Emily Scholl DMD, PA, LLC

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

First Name: ____________________________ Date: _________________

Last Name: ____________________________ DOB: _________________

I authorize Emily Scholl DMD, PA, LLC to release my medical records to:

Name: ____

Address: ____

City: ________________________ State: ______________ Zip Code:_____________

Telephone: ____________________________ Fax: ___________________________

I authorize Emily Scholl DMD, PA, LLC to release my medical records to:

€ All medical sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf

Please release the following documentation:

€ Complete Chart
€ Discharge Summaries
€ Consultations
€ Lab Work
€ X-Rays
€ Skin Tests
€ Other: _____________________________________

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature:_________________________ Date: ________________

AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

__________ First Request __________ Second Request __________ Third Request